Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: DR AHMED KHALIFA 1415 S HWY 6, SUITE 400D SUGARLAND, TX 77478	MFDR Tracking #: M4-09-B593-01
Respondent Name and Box #: AMERICAN HOME ASSURANCE CO. Rep Box # 19	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Fee guideline."

Principal Documentation:

1. DWC 60 package
2. Total amount sought - $16.70
3. CMS 1500
4. EOB's
5. Medical Report

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: The insurance carrier did not submit a response to the request for medical fee dispute resolution.

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
3/31/09	72040-26	97	1-7	$16.70
Total /Due:				$16.70

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.203, titled ***Medical Fee Guideline for Professional Services*** effective for professional medical services provided on or after March 1, 2008, set out the reimbursement guidelines.

1. These services were denied or reduced payment by the Respondent with reason code:
   - 97-Payment is included in the allowance for another service/procedure.
   - No reduction available.

2. Division rule at 28 TAC §133.307(c)(2)(B), effective May 25, 2008, requires that the request shall include "a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB." This request for medical fee dispute resolution was received by the Division on August 17, 2009. Review of the submitted documentation finds that the requestor did not submit reconsideration EOB. The requestor provided evidence of carrier receipt of the request for an EOB. Therefore, the requestor has completed the required sections of the request in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(c)(2)(B).
3. Division rule at 28 TAC §133.307(d)(2)(A)(i), requires "(A) The response to the request shall include the completed request form and: (i) all initial and reconsideration EOBs, in a paper explanation of benefits format using an appropriate DWC approved paper billing format, related to the health care in dispute not submitted by the requestor or a statement certifying that the carrier did not receive the provider's disputed billing prior to the dispute request." The respondent was notified of the dispute on September 21, 2009. The respondent did not submit a response to the request, reconsideration EOB, nor a statement certifying that the carrier did not receive the provider's disputed billing prior to the dispute request. Therefore, the respondent has failed to complete the required request form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(d)(2)(A)(i).
4. On the disputed date of service, the requestor billed the insurance carrier for CPT codes 64470, 64472, 72040-26 and 77003-26. The insurance carrier incorrectly denied reimbursement for CPT code 72040-26 based upon "97" because it is not included in the allowance for another procedure. Therefore, the disputed service will be reviewed per Rule 134.203.
5. Division rule at 28 TAC § Rule 134.203(b), the maximum reimbursement amount is determined by locality. The Medicare conversion factor for zip code 77027, Harris County, is 36.0666.
6. Based upon the submitted bill the place of service is 24-Ambulatory Surgical Care facility. The DWC conversion factor for professional services provided in a facility or an ASC by a physician is 66.32.
7. Per Division rule at 28 TAC § Rule 134.203(b), the MAR for CPT code 72040-26 is:

   DWC conversion factor of 66.32 divided by Medicare conversion factor of 36.0666 = $1.84 X Medicare allowance of $11.39= $20.96. The requestor is seeking reimbursement for $16.70; this amount is recommended for reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.1, 133.307
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $16.70 plus applicable accrued interest per Division Rule 134.130 due within 30 days of receipt of this Order.

ORDER:

		11/20/09
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.